THE PALLIUM PROJECT

A professional community of clinicians, educators, and academics
engaged in building Canada's palliative care capacity together

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Primary Palliative Care Professional

PROFILE OF MAJOR AREAS OF RESPONSIBILITY AND RELATED TASKS

MARCH 2002 (REVIEWED BY PARTICIPANTS)

Facilitated by:
Wilson Associates - Education Consultants Inc.

The PALLIUM Project

PALLIUM is a health human resource project focused on significantly improving access to system-linked education and professional development in palliative and end-of-life care for Canadian health care professionals and citizen-consumers, particularly in Alberta, Saskatchewan, Manitoba and North West Territories. The PALLIUM Project has received catalytic funding by Health Canada, under Budget '99 provisions creating the Rural and Remote Health Innovations Initiative (RRHII).

Major Funder (2001-2002)

Health Canada,
Rural and Remote Health Innovation Initiative

Project Hosting Authority

Alberta Cancer Board, Research Administration

Founding Academic Partners

University of Alberta

- Division of Palliative Medicine, Department of Oncology
- Academic Technologies for Learning, Faculty of Extension
- Institute for Professional Development, Faculty of Extension
- Division of Continuing Medical Education
- Division of Outreach Pharmacy Education, Faculty of Pharmacy and Pharmaceutical Sciences

University of Calgary

- Division of Palliative Medicine, Department of Oncology
- Office of Continuing Medical Education and Professional Development

University of Manitoba

- Section of Palliative Care, Department of Family Medicine

University of Saskatchewan

- Palliative Medicine Program, Department of Family Medicine and Department of Oncology

Founding Health Service Partners

Alberta Cancer Board, Research Administration
Calgary Regional Health Authority (CRHA)
Capital Health Authority, Edmonton
Caritas Health Group, Edmonton
Chinook Health Authority (Alberta)
East Central Health (Alberta)
Inuvik Regional Health and Social Service Board
Lakeland Regional Health Authority (Alberta)
Regina Health District
Saskatoon Health District
Stanton Regional Health Board, Yellowknife
Winnipeg Regional Health Authority

Other Founding Partners

Rural Physician Action Plan (RPAP), Alberta
Alberta Palliative Care Association

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Darby Johanson	Regional Palliative Care Coordinator; Norman RHA	The Pas, Manitoba
Eileen Peter	Family Physician; Member - Palliative Care Committee; Stanton Regional Hospital	Yellowknife, Northwest Territories
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Wilson Associates - Education Consultants Inc.

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PROFILE OF MAJOR AREAS OF RESPONSIBILITY AND RELATED TASKS

A Note on the Application of Occupational Analysis Methods to Health Professions' Education and Professional Development

The DACUM approach to educational program development has become widely known in Canada and the United States over the last 30 years as an effective means to involve front-line staff and leaders in the design of learning. It is based on the assumption that the people who actually perform a role or oversee it being done are the people who can best describe the role functions. The purpose of this modified DACUM workshop was to identify Major Areas of Responsibility and Major Tasks for health care professionals providing primary-level palliative and end-of-life care.

The DACUM approach is a systematic, analytic and descriptive process of gathering, documenting and analyzing information about actions that people in a particular role or job take in performing the tasks incumbent in that role. In this sense it is both explanatory and predictive as a needs assessment protocol. It also has the potential to lend itself well to the goal of designing education and professional development that is clearly linked to better patient care and quality and compassionate care outcomes.

This profile chart lists the *major areas of responsibility* and related *tasks* performed in this occupation.

The *major areas of responsibility* are listed vertically along the left-hand margin, in bolded boxes. These bolded boxes contain the title and alphabetical designation for each major area of responsibility (such as A, B, C, etc.).

The *tasks* that are performed within each major area of responsibility are listed in boxes and placed in horizontal bands beside the relevant major area of responsibility. Each task box contains the task description and an alphabetical and numerical designation (such as A1, A2, A3, etc.).

Professionals in this field provided the information in this profile chart. This analysis is a living document, which should be revisited, refined, and updated in future years.

DEFINITION

Primary palliative care professionals

provide direct and ongoing supportive end-of-life care,

for an individual and family by addressing

physical, emotional, social, cultural and spiritual needs

with dignity and compassion.

ESTABLISH THE PALLIATIVE INDIVIDUAL CASE **A**	Complete a thorough multi dimensional assessment - physical - psycho-social - spiritual A1	Determine patient's understanding of condition and expectations A2	Maintain connection with patient A3	Identify all possible sources of suffering e.g. physical, psycho-social, spiritual A4	Consider co-morbidity A5
	Facilitate the transition from curative to palliative care A6	Marshall appropriate resources in allied agencies to support individual/family in support activities A7	Identify and access other agencies who have been involved with individual A8	Establish and maintain a dynamic care plan A9	
MANAGE PAIN **B**	Assess pain e.g. - verbal - non verbal - history B1	Select and utilize appropriate pain assessment tools B2	Debunk myths related to addiction, tolerance and dependence B3	Apply comfort measures B4	Identify compatibility of medication B5
	Switch between opioids B6	Monitor pain control and adjust as required B7	Educate individuals and family on pain management B8	Follow up on medication changes B9	
MANAGE SYMPTOMS **C**	Recognize and treat common symptoms (see Appendix A) C1	Recognize and manage palliative care emergencies (see Appendix B) C2	Select and utilize appropriate symptom assessment tools C3	Manage side-effects of treatment regimes C4	Share expertise with other health care professionals regarding symptoms and pain management techniques C5
	Educate individual and family on symptom management and progress of disease C6				

COMMUNICATE IN A SENSITIVE AND RESPECTFUL MANNER **D**	Encourage family and individual to address legal/financial issues D1	Solicit individual and family collaboration D2	Advocate for individual and family D3	Listen actively! e.g. individual, family team, other resources D4	Recognize manifestation of and obviate iatrogenic suffering D5
	Utilize a variety of communication modalities e.g. written, oral, video, pamphlet and interpreters D6	Confirm patient's understanding of diagnoses, situation and choices D7	Educate patient and family on self advocacy when working with many health care professionals D8	Prepare individual and family on what to expect with various treatment regimes D9	Create a safe and secure communication environment D10
	Recognize individual right to choose and refuse treatment D11	Collaborate with other professionals and agencies D12			
ADDRESS GRIEF AND BEREAVEMENT ISSUES **E**	Reframe hope and healing E1	Recognize anticipatory grief when individual is living E2	Educate individual and family on loss and grief E3	Support bereavement education as part of health promotion and well being E4	Recognize when "normal" grief becomes "complicated" grief E5
	Respond to the special needs of young children and adolescents E6	Recognize and help caregivers to deal with their grief E7	Recognize community's grief E8	Consider fulfilling other multiple caregiver roles as required by community E9	

DEAL WITH ETHICAL/LEGAL REALITIES **F**	Address abusive relationships F1	Consider implications of prescribing opioids to individuals in high risk environments F2	Discuss advanced health directives F3	Address family dynamics issues F4	Address clinical/ethical issues e.g. -Tube feeding - Diagnostics - Nutrition hydration - Antibiotics F5
	Address health professional disagreements F6	Make decisions regarding the operation of a motor vehicle F7	Address workplace safety issues F8	Obtain family consent when necessary F9	
RECOGNIZE THE REALITIES OF PRIMARY PALLIATIVE CARE **G**	Recognize own limitations G1	Deal with treatment of a friend e.g. rural setting G2	Manage time G3	Seek to improve the integration and coordination of information G4	Recognize the implications of population, demographics, isolation, geography G5
	Cope with transient health care providers G6	Cope with limited resources G7	Acknowledge and respond to other health professional attitudinal barriers G8		
ADVANCE PALLIATIVE CARE PROFESSION AND INFRASTRUCTURE **H**	Serve as a role model H1	Build teams H2	Develop self care strategies H3	Reflect on own attitude and practices H4	Seek to improve one's own skills and knowledge H5
	Examine accountability parameters e.g. physician role, nurses role H6	Support inclusion of palliative care education in undergraduate and residency programs H7	Use and interpret research results H8		

RECOGNIZE AND TREAT COMMON SYMPTOMS

- Nausea/Vomiting
- Bowel Obstruction
- Dyspnea
- Secretions
- Delerium/Terminal Delerium
- Myoclonus
- Anorexia/Cachexia/Asthenia
- Anxiety/Depression
- Mouth Care Issues
- Constipation
- Edema/Ascites
- Dehydration
- Wounds

RECOGNIZE AND MANAGE PALLIATIVE CARE EMERGENCIES

- Spinal cord compression
- Superior vena cava compression
- Hypercalcemia
- Crisis shortness of breath/pain (sedation)
- Seizures
- Crisis hemorrage/bleed

AREA OR QUESTIONS REQUIRING FURTHER CONSIDERATION

- Improved health information systems and sharing of health information to assure seamless care
- Focused, collaborative steps among primary, secondary and tertiary levels to advance patient-centred care
- A recognition that family physicians need to allocate and protect time to address palliative care properly (may involve remuneration issues around cost of proper provision of palliative care service)
- Concerns about the mobility and transition of health care professional people and skills in rural and remote areas (e.g., high turnover)
- Health system organization affects the way we organize care and is often a barrier to continuum of care
- How do you get health care professionals to recognize what they do not know (i.e., lack of awareness about what constitutes properly designed and delivered palliative care)
- Providing “ongoing supportive” care may conflict with the episodic nature of current physician and care payment schedules
- Efficient and effective rural end-of-life care may include acknowledging disparity of diagnostic and specialty resources available in rural and remote areas (e.g., CT scanners, MRI, epidural)
- Recognition that a physician may not always be there – so, nurturing a work environment of shared accountability with nurses is essential, as well as nurses and other allied health professionals accepting greater ownership for being accountable in the overall care and active management of the palliative care patient
- A phenomena of “physician (or other care provider) as neighbour” in rural and remote contexts, may result in potential role conflict
- There needs to be fair physician and system compensation that accurately reflects the service and time requirements of providing proper palliative care
- Competency through volume of patients (i.e., construct of practice makes perfect) is a significant challenge in rural and remote contexts, so reference and supportive resources need to be in place to support the palliative professional

CHARACTERISTICS

- Blend of skill and kindness
- Display non-judgmental attitude
- Ability to impart knowledge through communication and training
- Humor

KNOWLEDGE

- Basic Oncology
  - palliative radiation
  - palliative chemotherapy
- Assessment tools (pain and symptom)
- Medications
  - ways to administer medications
  - WHO analgesic ladder
  - Understanding opioids
  - Adjuvant/alternative therapies
  - Compatabilities
- Common symptoms
  - side effects
  - types
- Palliative care emergencies
- Local resources and system capability
- Types of pain (comfort measures)
- Health care directives legislation in the jurisdiction of practice
- Occupational health and safety legislation and regulations (e.g., staff safety)
- Theory of anticipatory grief and normal grief

SKILLS

(some skills will be discipline specific)

- Maintain central I.V. lines
- Initiate/maintain hypodermoclysis
- Thoracentesis
- Paracentesis
- Manage infusion pumps (including programming)

PRIMARY PALLIATIVE CARE PROFESSIONAL

COMMENTS FROM THE PARTICIPANT REVIEW AND VALIDATION PROCESS (February 2002)

Introduction

All participants who were involved in identifying the Major Areas of Responsibility, the Major Tasks, and the Knowledge, Skills, and Characteristics for a Primary Palliative Care Professional were also asked to review and comment on the output. All participants (see page 03) were invited to respond to these three questions:

1) Are the findings presented in the attached document consistent with your personal and professional insights as shared during the DACUM process? _____ Consistent _____ Not consistent

2) If you answered "not consistent," what clarifying/explanatory notes would you add that might contribute to a final refinement of this document (please be concise and make reference to the question/questions/points you are addressing)?

3) Do you have any other suggestions or insights that you would like to share since you participated in the initial interview?

Results

The results were reported by respondents as consistent with what they developed during the modified DACUM workshop process. There was one respondent who reported "sort of consistent". In elaborating on this response, the participant noted the following:

"Palliative care also deals with end stages of illness (e.g., liver disease), congested heart failures, renal failures. Under the KNOWLEDGE section an individual [primary palliative care professional] needs to know the anatomy and physiology of the body and the disease process with which they are dealing. How can you help someone not knowing about the illness and what it is/will be doing to this person's body, mind, etc. I feel that anatomy and physiology of the body and disease processes be added to KNOWLEDGE."

Future Development of this Document

This DACUM report is intended as a "living document," representing a snap shot in time of a representative group of primary health care professionals from primary care and rural practices with a significant palliative care component. Comments and suggestions about the Major Areas of Responsibilities, Major Tasks, and Knowledge, Skills, and Characteristics of primary palliative care professionals can be sent by email to: Michael Aherne, PALLIUM Project Consultant, at maherne@ualberta.ca and/or Jose Pereira, PALLIUM Project Leader, at pereiraj@ucalgary.ca.